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INVITED COMMENTARY

Joseph D. Raffetto, MD, *West Roxbury, Mass*

In this study, Rasmussen et al provide a 5-year follow-up of the original randomized trial in which endovenous ablation was compared with ligation and stripping of the great saphenous vein in symptomatic patients with varicose veins that was published after 2 years of follow-up.[1] The importance of long-term data demonstrating durability and patient satisfaction after venous surgery is imperative and was previously demonstrated by Merchant et al[2] in a multicenter prospective registry.

For many years, it has been presumed that endovenous ablative techniques should be the primary treatment modality for the refluxing great saphenous vein and completely replace ligation and stripping. This contention was speculative and without scientific evidence. A small randomized trial by Lurie et al[3] in which endovenous radiofrequency ablation was compared with surgical ligation and stripping demonstrated that at 2 years of follow-up, in addition to similar treatment success and reduction in clinical severity, the endovenous ablation group had significantly reduced pain as a quality-of-life dimension compared with surgery that persisted up to 2 years.

Similar to the Lurie trial, the uniqueness of this study, however, is that it compares a well-validated surgical technique—ligation and stripping—with a relatively new treatment modality encompassing endovenous laser ablation, with important primary and secondary end points that mattered not only to the clinician but also to the patient and over a long period of post-treatment duration. Rasmussen et al found that both therapies were effective and had no differences in recurrent refluxing great saphenous vein, recurrent varicose veins, clinical severity, and quality-of-life analysis.

The strength in any study evaluating long-term results is the sample size in each group studied and the actual number of evaluable patients at each year interval, and in this study, at the 5-year follow-up. In addition to patient recruitment, understandably not all patients will be available to evaluate, and in this study, the authors recognize these limitations. However, this should not take away from the significance of this well-designed study, with well-matched groups and relevant end points that are critically important in clinical practice for physician caring for patients with venous disease. Although our confidence in treating patients with varicose veins with less invasive modalities will increase, there is a barrage of other modalities that have not been studied in a carefully designed randomized trial that await both professional and clinical acceptance. I believe the study by Rasmussen et al has set the framework for further work in this important field, that will answer which treatments, which outcomes, and what follow-up is necessary in determining best treatment practices for patients with varicose veins.

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